AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Name of Plan: South Dakota Risk Pool

Name of Individual: _____ **Telephone Number:** _____

This Authorization is provided in accordance with the Standards for Privacy of Individually Identifiable Health Information (the "Privacy Standards") issued under the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA").

If signed by the Named Individual: I am a participant in the Plan and hereby authorize the use or disclosure of my protected health information as described in this Authorization.

If signed by a personal representative of the Named Individual: I, _____, am the personal representative of the Individual, a participant in the Plan, and I hereby authorize the use or disclosure of his or her protected health information as described in this Authorization.

1. Person(s) or organization authorized to disclose the health information:

   _____

2. Person(s) or organization authorized to receive the health information:

   _____

3. Description of health information that may be used/disclosed:

   _____

4. Purpose for which the health information will be used/disclosed: *(**Note:** Not required if disclosure is requested by the individual)*:

   _____

5. I understand that the person or organization that I am authorizing to use/disclose the information may receive compensation in exchange for using or disclosing the health information described above.

6. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to enroll in a health plan, obtain health care treatment or payment or my eligibility for benefits.

7. Right to revoke: I understand that I have the right to revoke this Authorization at any time by notifying the Plan Administrator or the Third Party Administrator, in writing, at the appropriate address set forth above. I understand that the revocation is only effective after it is received and logged by the Plan Administrator or the Third Party Administrator. I understand that I cannot revoke this authorization to the extent that (a) the Plan has taken action in reliance of this authorization (for example, any use or disclosure made prior to the revocation under this Authorization will not be affected by the revocation) or (b) the authorization was obtained as a condition of obtaining insurance coverage and other law provides the insurer with the right to contest a claim under the policy or the policy itself.

8. I understand I may inspect or copy any information to be used or disclosed under this authorization.

9. Unless otherwise revoked in writing, this authorization will expire 90 days from the date signed below OR upon the occurrence of _____.

_____ _____

Signature of Individual (or Legal Representative) Date

_____

(Print) Individual's Name

_____ _____

(Print) Name of Legal Representative (if applicable) Relationship to Individual

Note: HIPAA "covered entities" (e.g., health plans) must provide a copy of the signed authorization to the individual.